The City of Milwaukee Health Department's

Third Annual Infant Mortality Summit:

Changing the Determinants of Health

Summary Report

June 6, 2012

Italian Community Center • Milwaukee, Wisconsin

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A Message from the Mayor of Milwaukee and the Commissioner of Health

Dear Friends,

This report is a summary of the 3rd Annual Infant Mortality Summit. This year's Summit focused on the social and economic factors that have long-term, downstream effects on health, and especially on birth outcomes. These factors – like early childcare and education, income and poverty, healthy neighborhoods and employment issues (among others) – are known as the *social determinants of health* (SDoH).

There are many ways to work to address these upstream factors, but one critical way is through policy change. Given that roughly 40% of what impacts general health is related to SDoH, Milwaukeeans need to feel empowered to work with elected officials to create new policies, and change existing policies, in order to better support health in general and healthy babies in particular.

The goal of this year's Summit was to increase awareness and understanding of how social determinants of health impact infant health, how policy change can be used to modify these determinants, and finally to begin to think about your own role in changing the social determinants as a way to improve healthy birth outcomes.

The Health Department has started this critical conversation. Working on improving the social determinants of birth outcomes will require a wide investment and collaboration around the city and beyond. It is through these united efforts that Milwaukee will turn the tide on infant mortality.

We hope you find this report to be interesting and of use in starting conversations and changes within your own communities and organizations.

Sincerely,

Tom Barrett
Mayor

Bevan K. Baker
Commissioner of Health

Introduction

The City of Milwaukee Health Department hosted its 3rd Annual Infant Mortality Summit with a focus on Social Determinants of Health on June 6th, 2012. The Summit convened key community partners from around the city to discuss ideas on how we can collectively influence the social determinants through policy change. With 300 participants, a wide range of policy solutions were discussed, including healthy neighborhoods, employment, income, and early childhood education. Participants also had a chance to attend a policy and advocacy discussion to learn more about the basics of advocacy and policy change.

Participation in the summit was diverse. Some came to hear about social determinants for the first time, while some came to learn about how they can apply their social determinants knowledge to their practice. Participants enjoyed the opportunity to connect with others in the region around this topic and have a discussion about the root causes of infant mortality. Many participants also commented that they would be interested in connecting with others to continue the conversation after the Summit, as well as work on action steps collectively.

Dr. Anthony Iton, Vice President of the California Endowment was the opening keynote speaker. He made the case for why public health professionals should not only care about social determinants and policy change, but have a responsibility to contribute at that level through their work. Dr. Magda Peck, the Founding Dean of the UW-Milwaukee Zilber School of Public Health, was the closing speaker and inspired the crowd by presenting a framework for action and partnership.

There was a high level of enthusiasm in the crowd for the keynote speakers, as well as the conference overall. Many participants felt that the Summit offered a fresh, inspiring perspective on a topic that is often not well understood, and that they were leaving the Summit with clear ideas for implementing strategies related to social determinants of health and healthy policy change.

As Dr. Iton explained, effectively reducing infant mortality requires a strong focus on the social determinants of health. The City of Milwaukee Health Department is committed to working collectively on these issues; examples of that commitment include partnering with the Milwaukee Lifecourse Initiative for Healthy Families (LIHF), collaborating with the UW-Milwaukee Zilber School of Public Health, and founding and housing the Wisconsin Center for Health Equity.

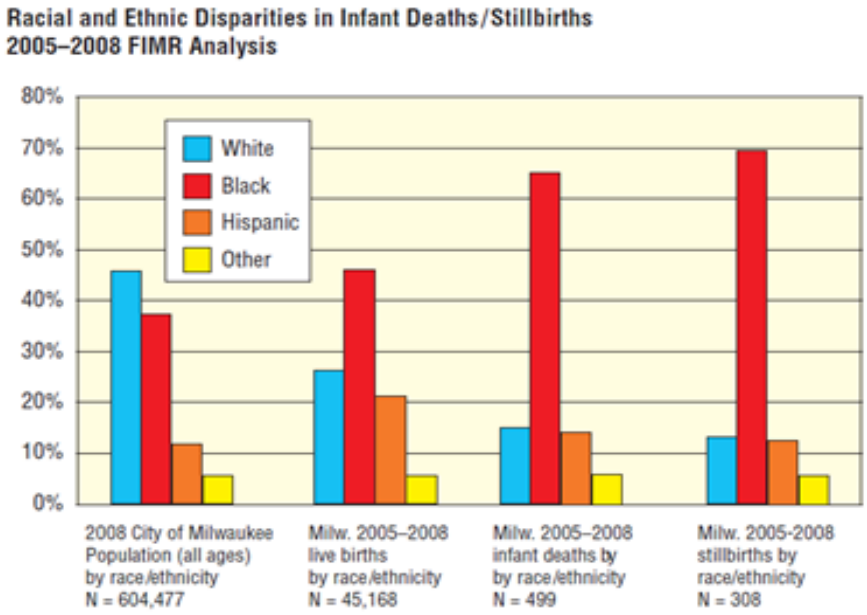
This report provides the synopsis of the summit. It includes a summary of both the opening and closing keynote presentation. It also provides a summary and detailed notes of each breakout session.

Making the Case:
Social Determinants of Infant Mortality

The Infant Mortality Rate (IMR) in any location is calculated by comparing the number of infants who died prior to their first birthday in a particular year to the total number of live births in that same year. City of Milwaukee Health Department data show that the overall city infant mortality rate (IMR) in 2011 was 9.8 (i.e., 9.8 infant deaths per 1,000 births). For Milwaukee's non-Hispanic white families, the IMR in 2011 was 4.2. For the same year, the Hispanic rate was more than twice the white rate at 8.9 and the non-Hispanic black rate was 14.3 per 1,000 – over three times the white rate.

The city of Milwaukee's black-white infant mortality gap is among the highest in the nation. In fact, the black infant mortality rate in Milwaukee is worse than the rate in Jamaica, Ukraine, Costa Rica, Ecuador, Malaysia, and many other countries. Figure 1, taken from the 2010 Milwaukee Fetal Infant Mortality Report, highlights the disparity clearly by showing the percentage of infant deaths attributable to various racial and ethnic groups.

Figure 1: Racial and Ethnic Disparities in Infant Deaths/Stillbirths.

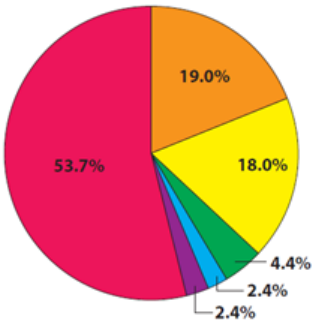


Source: 2010 City of Milwaukee Fetal Infant Mortality Review (FIMR) Report: Understanding and Preventing Infant Death and Stillbirth in Milwaukee; 2005–2008 Stillbirths and Infant Deaths.

What causes such high rates of infant mortality in Milwaukee?
Figure 2 describes the range of causes of infant mortality in Milwaukee, with prematurity as the leading cause. There are many other causes, from maternal smoking to sleep environment to sudden infant death syndrome (SIDS), and from sexually transmitted diseases (STDs) to lack of prenatal care.

Figure 2: Causes of Infant Death in Milwaukee, 2005-2008.

All Milwaukee Infant Deaths, 2005-2008



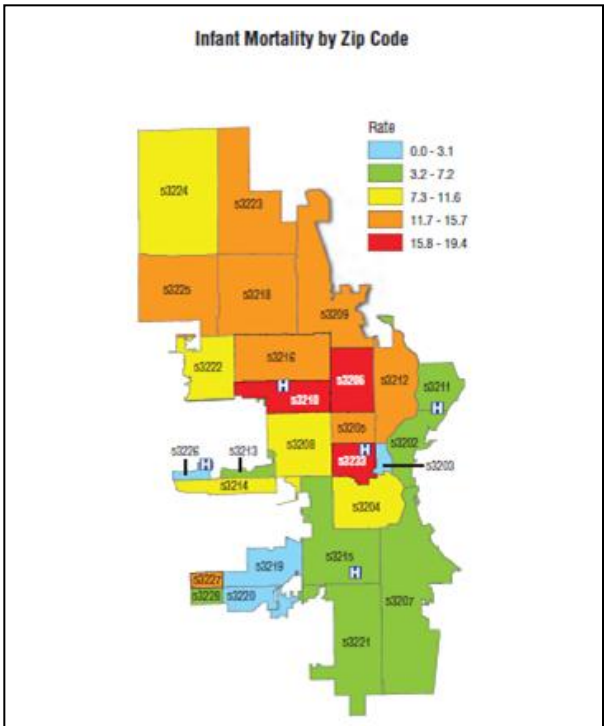
Causes of Infant Death in Milwaukee, 2005-2008

Cause of Death	Key	Black	Hispanic	White
Complications of Prematurity		193 (58.7%)	35 (49.3%)	32 (41.0%)
Congenital Abnormalities and Related Complications		39 (11.9%)	26 36.6%)	23 (29.5%)
SIDS, Overlay, Accidental Suffocation		65 (19.8%)	4 (5.6%)	16 (20.5%)
Infections		16 (4.4%)	2 (2.8%)	4 (5.1%)
Homicide		8 (2.4%)	2 (2.8%)	1 (1.3%)
Other		8 (2.4%)	2 (2.8%)	2 (2.6%)

Source: 2010 City of Milwaukee Fetal Infant Mortality Review (FIMR) Report: Understanding and Preventing Infant Death and Stillbirth in Milwaukee; 2005–2008 Stillbirths and Infant Deaths.

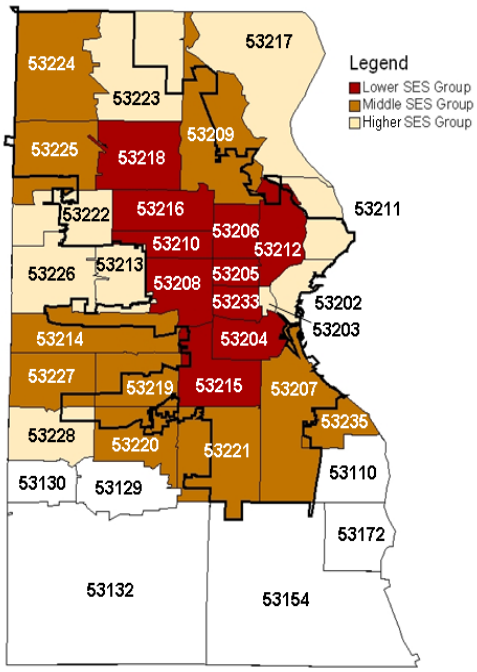
However, these risk factors tell only a part of the story. When we map the distribution of infant mortality in Milwaukee, we see the burden of infant mortality is clustered in certain zip codes (Figure 3). This distribution closely corresponds to these zip codes' socioeconomic status (SES), which is a marker of the poverty and education level in the community (Figure 4).

Figure 3: Milwaukee IMR by ZIP code



Source: 2010 City of Milwaukee Fetal Infant Mortality Review (FIMR) Report: Understanding and Preventing Infant Death and Stillbirth in Milwaukee; 2005–2008 Stillbirths and Infant Deaths.

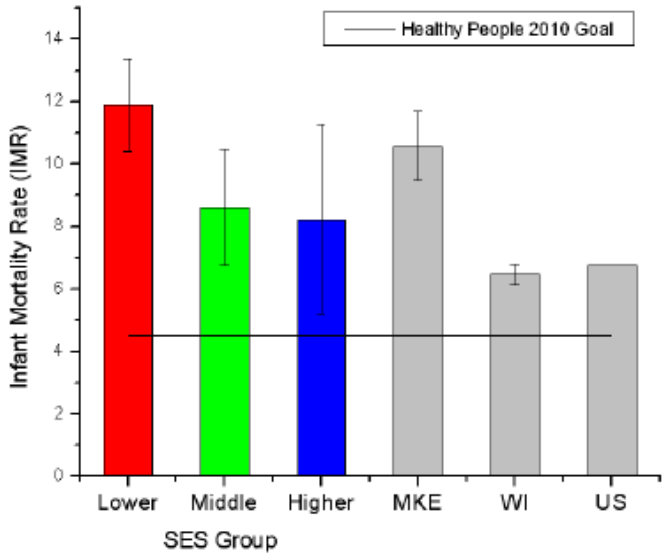
Figure 4: Milwaukee ZIP code groups by SES



Source: Milwaukee Health Report 2011; Center for Urban Population Health and the City of Milwaukee Health Department

It is easy to see the overlap between the maps in Figures 3 and 4. In fact, as shown in Figure 5, the IMR of Milwaukee's lower SES ZIP codes (11.9) is 45% higher than for the higher SES ZIP codes (8.2).

Figure 5: Milwaukee IMR by SES group, compared to overall Milwaukee, Wisconsin and US rates.



Source: Milwaukee Health Report 2011; Center for Urban Population Health and the City of Milwaukee Health Department

SES Group	# Live Births	# Infant Deaths	Infant Mortality Rate (IMR)	95% CI
Lower	20,441	243	11.9	10.4 – 13.4
Middle	9,509	82	8.6	6.8 – 10.5
Higher	3,400	28	8.2	5.2 – 11.3

Many researchers now agree that SES – or social determinants of health (SDoH) more broadly – is the most influential factor in health, more powerful than medical care or even individual health behaviors. The health outcomes we see, such as infant mortality, can be seen in some ways as symptoms of the underlying problems reflected by socioeconomic status – e.g., poverty and low educational attainment.

However, social determinants of health include more than traditional basic measures of SES (e.g., income, employment, education), and extend to other factors such as social cohesion and support, community safety, discrimination, affordable housing, and food security.

Although researchers are still trying to figure out all of the details of these relationships, there are already good explanations about how poverty, unemployment, low educational attainment, and other social determinants of health influence infant mortality.

Obviously, educational or economic barriers to accessing health care can lead to higher rates of infant mortality. However, the picture is more complex than that. Recent research also shows that stress over a lifetime can make it more likely that a woman will give birth prematurely. This can happen not only because of barriers to accessing healthcare, but also because chronic stress can cause the release of hormones that make premature labor more likely, and can also cause inflammation in the placenta, leading to less blood flow and less oxygen to the baby during pregnancy. Some people believe that this chronic stress is one explanation of how factors like poverty and racism make infant deaths more likely. Moreover, these factors affect many other health issues beyond infant health, including diabetes, cancer, and many other chronic diseases. More details on the role of chronic stress can be found on page 12 of this report.

What can be done to improve social determinants of health?

Infant mortality is a complex problem with no single solution. Rather than just being an issue of health care access, health care quality, or individual behavior, there are numerous social, economic and racial/ethnic issues that play extremely important roles.

The vast majority of US investments in health overall are at the level of access to, and quality of, individual clinical interventions. Even public health initiatives have focused on individual service provision such as prenatal care, screening for STDs, social services for new mothers, and health education.

However, the overarching social structure and policy environment produces powerful effects on individuals and groups that account for an outsized proportion of the inequities in health outcomes. Therefore, to be most effective, professionals dedicated to improving health — including public health professionals and practicing clinicians — must *not only* continue our traditional roles, including promoting healthy behaviors and access to quality healthcare. We must also balance our repertoire by adding the skills, competencies, tools, and methods to address the broad policies, systems and environments that so strongly influence health, including taking an active role in the process by which policies are made.

This policy work must focus on multiple areas with which we may be relatively unfamiliar — policies that drive the systemic root causes of health and disease in our communities — for it is these policies that both support (or constrain) healthy behaviors as well as directly affect individual physiology, both of which drive health or illness, the eventual need for health care, and poor health outcomes such as preterm birth, low birthweight, and infant mortality.

This comprehensive approach needs strong support from policy makers, and must include policies and programs that address the upstream, socioeconomic factors that are key influencers of the high infant mortality rates. This work can be supported through the following activities:

1. Educate policymakers and others on the socioeconomic determinants of health that are causing poor infant outcomes in our communities, as well as on the health impacts of various existing policies or any new policies they may be considering.
2. Encourage and support changes in public policy related to social and economic determinants of health in order to improve the health of all Milwaukeeans, especially those at highest risk for poor health outcomes.
3. Build community involvement in policymaking that will improve socioeconomic conditions for everyone in our community.

Sustainable and high impact solutions require a concerted and collaborative effort to implement policies to improve SDoH in multiple areas. Such policy changes, in turn, will improve health outcomes in many areas, including infant mortality.

Speaker Summary

Dr. Anthony Iton, MD, JD, MPH
Opening Keynote Speaker

Biography
Since 2009, Dr. Iton has served as Senior Vice President of Healthy Communities for the California Endowment. The California Endowment is the state's largest private health foundation, and its ten-year goal is to create communities where children are healthy, safe and ready to learn. Prior to his appointment at The California Endowment, Dr. Iton served as Director and Health Officer for the Alameda County Public Health Department. In that role, he oversaw the creation of an innovative public health practice designed to eliminate health disparities by tackling the root causes of poor health that limit quality of life and lifespan in many low-income communities.

Dr. Iton also served for three years as Director of Health and Human Services, and School Medical Advisor, for the City of Stamford, Connecticut. Concurrent to that, he also served as an internal medicine physician for Stamford Hospital's HIV Clinic. In addition, Dr. Iton served for five years as a primary care physician for the San Francisco Department of Public Health. Dr. Iton, who has been published in numerous public health and medical journals, earned his Bachelor of Science in Neurophysiology, with honors, from McGill University in Montreal, Quebec, his law degree at the University of California, Berkeley, and his medical degree from Johns Hopkins University School of Medicine.

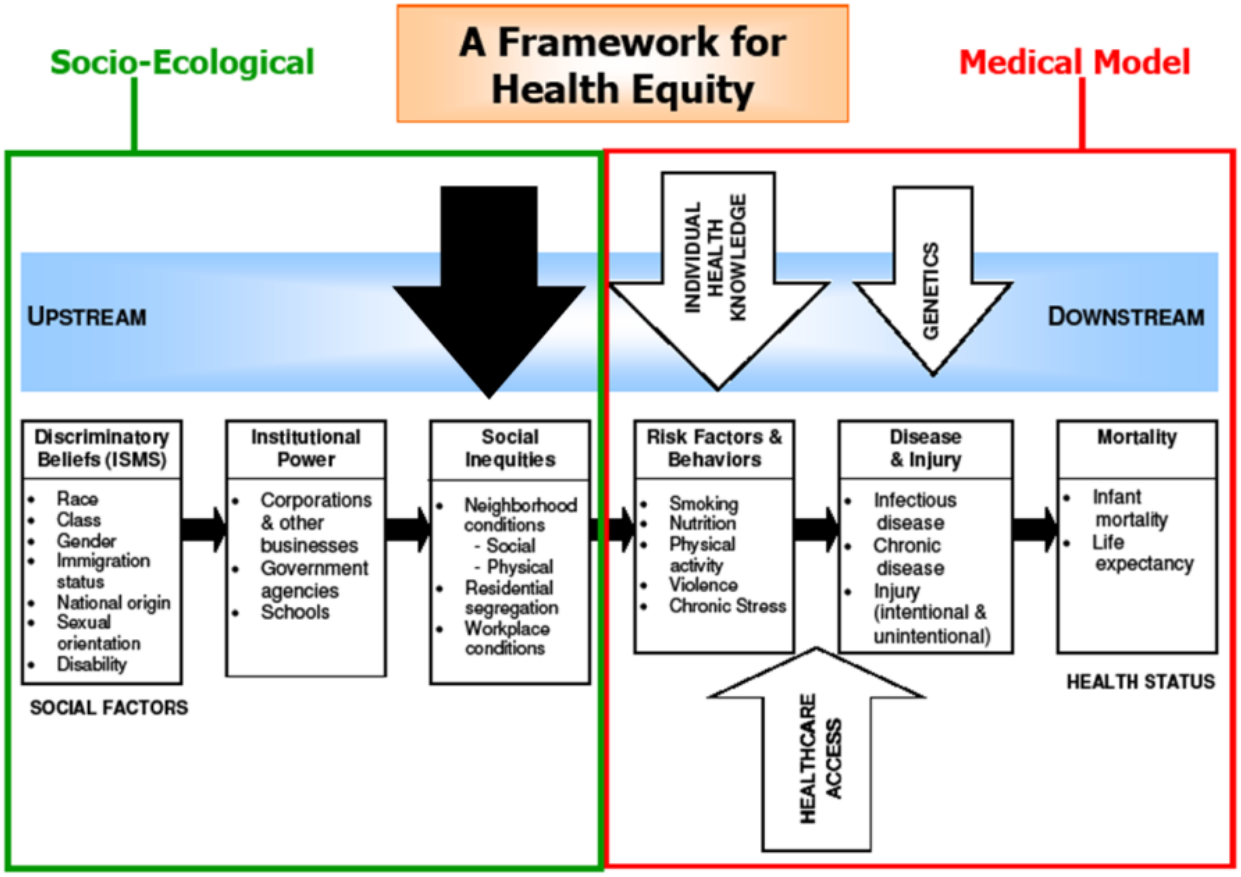
Summary of Dr. Iton's Opening Keynote:

- **Health is Political.** Dr. Iton described politics as a struggle for the allocation of scarce social goods. If you are not participating in the process, you will not get fair allocation. Leaders in public health are needed to participate in this process.
- **Health does NOT equal health care**. Where you live matters, and it matters A LOT. Dr. Iton presented maps of Alameda County in California that mapped available services, including health care. He pointed out that areas with the highest concentration of available services are also areas with the worst health outcomes. This implies that there is more to health than availability of services.
- **Your zip code matters more than your genetic code.** Dr. Iton described how your neighborhood can "get under your skin." He also described how the environment can be internalized through accumulation of stress and affect the way our internal organs function. Furthermore, some groups are historically and intentionally segregated from others, which can also affect health through factors such as worse quality of education, employment opportunities and neighborhood safety.
- **There are no silver bullets.** The problems described by Dr. Iton are complex and require complex solutions. There is no single initiative or policy that will undo the landscape that has been created over centuries. Dr. Iton presented three main ingredients needed to improve health:
    - Narrative: change the narrative from one that blames individuals to one that acknowledges the institutionalized nature of the problems that plague individuals.
    - Power: build capacity of communities to successfully lead efforts that will improve health.
    - Policy: leverage the experience and expertise of various stakeholders to successfully bring collective impact through policy change.
- **Stop waiting for Washington.** Long-term and sustainable communities start at the community level with communities advocating for policy change. High impact policy change can occur at any level – not only at the federal level.

Detailed Notes of Dr. Iton's Presentation

Dr. Iton's presentation provided 21st Century public health framework, as seen in the Figure 6. These notes will concentrate on describing each portion of the framework, represented by the boxes.

Figure 6: A Framework for Health Equity:



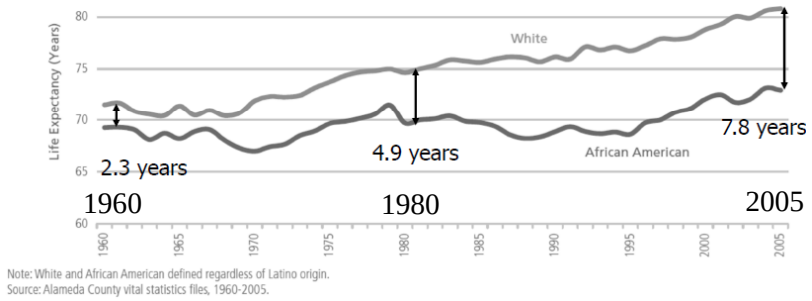
- Adapted by ACPHD from the Bay Area Regional Health Inequities Initiative, Summer 2008

Mortality: Public health focuses significant effort on mortality, including infant mortality and life expectancy. There are two key points to understand about mortality numbers. First, it is important to understand that there are human trajectories and that it is best to intervene early in the trajectory rather than later. Second, it is important to spot patterns and then to explain them. It is not enough to only show the data; it is critical to explain what is driving the data.

In Alameda County, Dr. Iton has used death certificate data to calculate life expectancy. He feels that life expectancy is an easier concept for people to understand than infant mortality, and the patterns between the two are very similar. From death certificate data, it is possible to get four important pieces of information: reason for death, age, race/ethnicity and zip code. From there, Dr. Iton created a database to help analyze the distribution of data geographically.

The surprising results can be seen in Figure 7 below. In the 1950s and 60s, there was a very small gap in life expectancy between African Americans and Whites. It is hypothesized that at that time, many African Americans "immigrated" to the West coast for jobs and immigrants tend to be healthier than Americans. However, after the '70s, the gap in life expectancy widened despite the growth in the health care technology and pharmaceutical industry. Even after controlling for HIV and homicides, this difference persisted. In fact, most of the deaths could be attributed to preventable chronic diseases, e.g., cancer, heart disease.

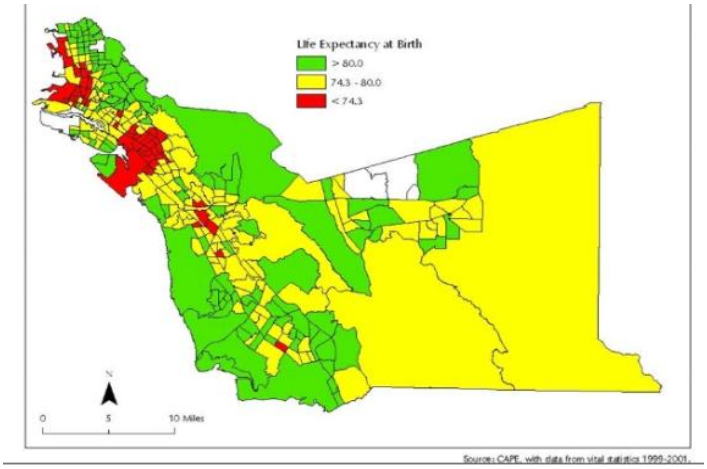
Figure 7: Historical Life Expectancy at Birth, Alameda County



Note: White and African American defined regardless of Latino origin.
Source: Alameda County vital statistics files, 1960-2005.

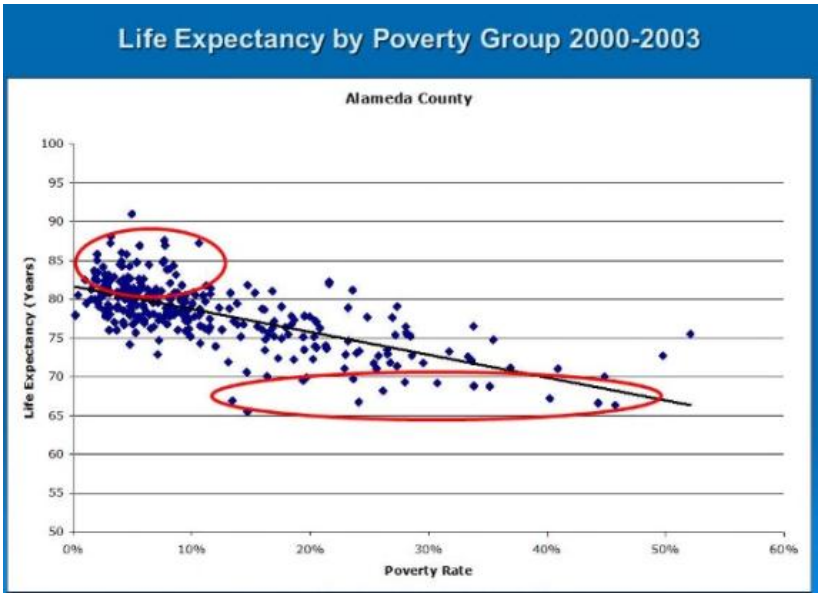
Furthermore, when life expectancy is mapped geographically, one can see hotspots (Figure 8). In some neighborhoods, people die up to twenty years earlier than people in other neighborhoods. This has been replicated in Seattle, Los Angeles, Baltimore and Cleveland.

Figure 8: Life Expectancy by census tract, Alameda County



When Dr. Iton mapped life expectancy against poverty (Figure 9), a strong correlation was found: the higher the poverty rate, the lower the life expectancy. He called this the death tax: it is the price you pay (in length of life) for living in a poor neighborhood. Further, the slope of the line in the graph below can be translated: every additional $12,500 in annual income can buy you an additional year of life.

Figure 9: Life Expectancy by poverty rate, Alameda County



Some people wonder if this is merely correlation and not causation. Causation has been proven through a long-term longitudinal study in Alameda County that calculated the cost of being poor. It found that if your income is one standard deviation above the mean, you are 25 percent less likely to die prematurely. If your income is one standard deviation below the mean, you are 35 percent more likely to die prematurely. This implies that we need to focus on what is driving disparities, instead of the disparities themselves.

Disease/Injury: Public health and healthcare professionals are taught that many of the reasons for disease burden are genetic. Researchers spend a lot of time looking for a genetic explanation for various diseases, including infant mortality. However they always find the same answer – that there is not a genetic explanation for infant mortality. This is evidenced by the fact that African immigrants have better birth outcomes than African Americans. For future generations of immigrants, however, birth outcomes become closer to African Americans.

Some people think that if genetics is not the answer to infant mortality, then it must be health care. In Alameda County, the disparity gap for prenatal care has been almost closed, however the infant mortality rate disparities persist.

Risk Factors/Behaviors: The medical model suggests that the differences in life expectancy can be explained in large part by health behaviors, implying personal responsibility. In fact, beyond our investments in healthcare, we invest a great deal of money on preventive and social services to individuals - - e.g., drug treatment programs, smoking cessation programs, etc. Unfortunately, this service delivery investment a) tends to be remedial in nature, b) does not address underlying conditions, c) is expensive and difficult to sustain, and d) has had no sustained impact on health disparities.

Dr. Iton mapped out who gets these services in Alameda County, including health and social services, parole and probation services. The provision of these services is most highly concentrated in 13 census tracts. Within these thirteen census tracts, $93 million is spent on services per year – approximately $6,000 per household. These are the same census tracts that have high poverty rates, high unemployment, low educational attainment, low home ownership rates, and are largely made up of people of color. When further analyzed, most of that $93 million is spent on paying salaries to people who provide the services — people who mostly live in the suburbs rather than in the affected neighborhoods.

Dr. Iton argued that in public health the problem is not based on how much money we have, but rather has to do with how we spend the money and where we invest it. He reasoned that we can use the existing money in a way that can bring double benefits to the communities we are trying to "serve" by investing in upstream social and economic determinants of health in these communities.

Social Inequities: Dr. Iton argued that neighborhood characteristics, such as physical and social environments, impact behaviors strongly. In fact, a person's zip code is one of the strongest predictors of life expectancy. The biology of this can be explained through the concept of allostatic load, or the accumulation of chronic stress. He argued that we all have stress, but the more important factor is if we have the resources to deal with the stress. Under-resourced and/or unmitigated stress is harmful and leads to chronic disease through the increase release of hormones like adrenaline and cortisol, which in the short term can affect placental blood flow and uterine contractions, and in the long-term can increase inflammatory responses, impair glucose metabolism, decrease immune response, and cause premature aging. This concept is especially important in children, with evidence showing the strong influence of childhood stress on chronic disease later in life.

Institutional Power: Neighborhood conditions are created through policy that determines where resources are invested, for example investment in public transportation or schools, density of liquor stores, or availability of mortgage loans. These policy decisions stem from powerful institutions, both private (e.g., corporate) and public (e.g., government). These neighborhood conditions not only contribute to chronic stress, but also constrain individuals' ability to engage in healthy behaviors.

Discriminatory Beliefs: This differential investment in resources is, in turn, based on discriminatory beliefs that devalue certain populations, based on race, gender, geography, immigration status or sexual orientation. These beliefs shape the policies that create conditions we see in certain neighborhoods. Dr.

Iton cited the federal housing policy ("red-lining") that was in place until the 1950s to keep certain races out of certain neighborhoods. Red-lining practices also kept resources and investments from being allocated to neighborhoods that were deemed toxic – based on discriminatory beliefs. This kind of segregation can affect health in several ways by a) constraining access to quality education and employment opportunities; b) creation of unhealthy neighborhoods and housing conditions; c) constraining practice of healthy behaviors and encouraging unhealthy ones; and d) constraining access to quality health care.

Dr. Iton summarized that health can be viewed through two lenses, as shown in Figure 6 above. Traditionally, we look through the lens of the medical model, which sees "disparities." However, the socio-ecologic model sees the upstream conditions that are driving these disparities. In other words, the medical model focuses on the consequences that are visible (health outcomes), and the socio-ecologic model reflects the conditions that lead to the consequences. The consequences can manifest themselves in myriad ways (e.g., cancer, stroke, diabetes, teen pregnancy, infant mortality, etc.); however the key conditions that result in these consequences are always the same – as described through social inequities driven by differential investment in certain neighborhoods and populations.

The new practice of public health must take the socio-ecologic model into account. This can be done in three ways:

- *Place.* Public health must engage people most impacted in crafting solutions to their own problems. This helps build power in communities to impact their situations.
- *Policy.* It is critical to bring the force of organized communities into the policy making arena. This includes demonstrating the health impact of "non-health policy."
- *Narrative.* If we continue to tell the story based on individual behaviors and medical care, then the solutions will be narrowly focused on changing behaviors and increasing access to (and quality of) medical care. The narrative must be changed from one that focuses on blaming individuals to one that looks through a wider lens at the historical and current policy context that has caused the problems we see today.

Dr. Iton spoke briefly about the work he is doing at the California Endowment. They have chosen to invest $1 billion over ten years in human capital – focusing on upstream determinants. Their approach is to build power in communities, forge collaborative efficacy and leadership, empower youth to lead, leverage partnerships, and change the narrative. For example, their Grocery Store Initiative is a private-public investment to create grocery stores in poor neighborhoods. They put $30 million into a fund and invited private donors who wanted a return on investment at market value. They were able to increase their initial investment to $263 million dollars and will be able to build more grocery stores than they had initially anticipated.

In conclusion, public health is not just about data analysis and individual service delivery – it is about building relationships across sectors to construct a common purpose. In our society, power is relational and we must invest time and effort to build these relationships. For a healthier society, we need more people participating in setting priorities and making decisions - - optimizing the democratic process, including civic engagement. What public health can bring to the table is a) its ability to forge relationships and b) an agenda that is not based on "special interests," but rather based on data and expertise on health and its determinants.

Speaker Summary

Dr. Magda Peck, ScD
Closing Keynote Speaker

Biography

Dr. Magda G. Peck is a national public health leader dedicated to bridging academe and practice to improve the health and well-being of women and children, fathers and families. On March 1, 2012, she became founding Dean of the Joseph J. Zilber School of Public Health at the University of Wisconsin-Milwaukee. She is Senior Advisor, Founder, and former CEO of City-MatCH, and served as Associate Dean for Community Engagement and Public Health Practice at the University of Nebraska's first College of Public Health. She holds master's and doctoral degrees from the Harvard School of Public Health.

Dr. Peck has worked closely with local, state and federal organizations in the public and private sectors to increase the capacity of individuals and organizations to improve maternal and child health in urban communities. Her areas of expertise include applied epidemiology, public health planning and needs assessment, building data capacity for public health, and child health research. She is a recognized as a community leader who works closely with public and private sectors. In 1999, Dr. Peck was the first recipient of CDC's new Maternal, Infant, and Child Health Epidemiology Award for Building Data Capacity for MCH at the National Level.

Summary of Closing Keynote:

Dr. Peck provided positive and energizing closure to the Summit and gave everyone three important points to consider as to why we are not always successful in our efforts to decrease infant mortality:

- **It is really complicated.** Public health problems are complex and require complex solutions. We have to be able to connect all the pieces of the larger system and approach problems for a system level, not just the downstream effects that are most visible.
- **We are not being clear about our framework with each other.** Each of us has a specific perspective with which we view the world and that influences our approach to public health. We need to be able to make our perspective visible to ourselves and each other in order to get to collective action.
- **We are not holding each other and ourselves accountable.** We must measure and evaluate the outcomes and impacts of our work in order to continue to make progress in addressing public health problems, including birth outcomes.

Dr. Peck explained how we can work together to make this happen through the metaphor of her grandmother's pearls. There are three things that make a strand of pearls so durable that they can be passed on from generation to generation:

- Each individual pearl counts. Each one is important. Every individual in public health has something unique to offer to the effort.
- The best strategy to keep pearls from scattering if the string breaks is by putting a knot between each pearl. This keeps the connections between pearls strong, but leaves a little space between the knots. This space allows us to be honest with each other as we hold each other accountable.
- The clasp is critical. As collaborative leaders, we need to be able to open and close the clasp as needed to bring people together in a strategic coalition.

Breakout Session Summary
Public Policy/Advocacy 101

Discussion Leaders:

Jennifer Gonda – Acting Director, Intergovernmental Relations, City of Milwaukee Health Department

Rob Henken – President, Public Policy Forum

Summary:

This session provided an overview of the policy and political process. Both Jennifer Gonda and Rob Henken are policy experts in Milwaukee and provided useful insight for the participants to take home. Rob Henken gave a brief overview of the political structure at the federal, state and county levels. He spoke about the need to understand the various types of legislation at the federal level:

- Authorizing legislation: bills that create new federal programs, extend the life of an existing program, or repeal existing law. Authorization bills also establish the maximum amount that can be spent by a program or government entity over a period of years.
- Appropriations legislation: bills that allocate specific dollar amounts on an annual basis for specific federal programs. Each year, Congress must pass thirteen appropriations bills to keep federal departments and agencies operating.
- Entitlements legislation: bills that guarantee a certain level of benefits to persons who meet eligibility requirements set by law, such as Medicaid, Medicare, and college student loan programs. Entitlement programs typically do not require annual appropriations.

Further, he described the importance of understanding the committee structure at each level of government and who has the power to make decisions. Committees exist to oversee executive departments, consider policy details, establish new policies and adopt policy changes. The committees are where many decisions are made and are often the first place to go to for advocacy. The finance committees are always the most powerful as they make most of the decisions about the budget.

Jennifer Gonda provided a deeper overview of the advocacy process by providing some key tips:

- Differentiate between public and private problems. It is difficult to come up with a public solution for a purely private problem.
- Consider the scope of your problem and solution. Narrow your scope to something that can give you a very specific, manageable solution.
- Use personal stories. This will help policy makers understand why your issue is important. Legislators often do not respond well to pure facts, but can appreciate a story that illustrates the same problem and solution.
- Provide a sense of urgency.
- Make sure your policy solution is feasible and fairly easy to implement.
- Tailor your policy solution to the political climate.
- Get consensus amongst your various stakeholders so there are no arguments once it comes time to lobbying.

Notes: The discussion in this section was structured as a back-and-forth between the participants' comments and the presenters who responded to participants' comments. Six main themes were discussed:

- **Avoiding unintended consequences.** When a policy is made in a top-down fashion, there are often unintended consequences. It is crucial to bring diverse stakeholders into the planning process. It is especially important to gather input and feedback from constituents and other community members.

- **Legislative versus executive policy change.** The first thing to consider regarding a policy solution is whether it needs to be implemented through an administrative rule change or through the legislature. A rule change can be easier than trying to pass new legislation. Second, often the easiest solutions to pass are the ones closest to home. When you have a policy solution, especially one that concerns large programs like Medicare or Medicaid, think of the lowest level of government that you can influence. For example, some federal programs are administered through states or counties. It may be easier to start by going to the county level than to the federal level.

- **City government involvement in employment issues.** The city is involved in employment in two ways: a) through its workforce investment board which connects employers and employees through various job opportunities, and b) through economic development that invests tax dollars to sites or companies to develop in the city. However, a policy focus on employment is too big and must be broken down. Consider starting at a neighborhood level and where you would like to see an employer located. Also consider the hiring practices of that employer.

- **Window of opportunity for policy change.** To pass any policy, there is a specific window of opportunity that depends on several factors, including identification of a realistic solution, right political climate, urgency to your solution, and the right champions for the solution. All the pieces are needed.

- **Getting your message out to elected officials.** Often politicians have a short attention span and are not impressed with large amounts of data. Consider developing a one-pager, or prepare a personal story and include a map that shows your story. Further, people in positions of power are not predisposed to agree with you. Politicians who are not from Milwaukee will not naturally care about Milwaukee issues. We need to work to find common ground.

- **Choosing policy solutions.** Avoid issues of social policy that are divisive. Don't spin your wheels on policies that are not politically viable. Start with small solutions that can serve as building blocks to bigger, more impactful policies.

Breakout Session Summary
Early Education and Childcare Policy

Discussion Leaders:

Christine Holmes – President, Penfield Children's Center

Aaron Schutz – Associate Professor and Chair of the Department of Educational Policy and Community Studies, University of Wisconsin-Milwaukee

Summary:

This session was intended to begin a dialogue about policies related to early education and childcare. Two different perspectives were provided, an academic and a community one. Aaron Schutz, a professor at UWM, discussed how power works and the role of community organizing. He observed that people in power are often well organized, have institutional command (they can make people do things) and have a place as a "power player", meaning they sit a tables where decisions are made. Communities can build power by organizing people. This can be done by engaging communities in strategic collective action. Dr. Schutz also provided some context for three important community organizing principles.

- **"Problem" vs. "issue."** These terms have different meaning in community organizing. A problem is overwhelming and makes you feel like you can't do anything (e.g., world hunger, bad schools). An issue is a specific, do-able, solution to your problem (e.g., raise $3 million for food bank, reduce class size to 16).
- **Characteristics of a good issue.** When a community is choosing an issue to work on, it must consider several criteria. The issue should be specific, framed in simple and clear language, be deeply felt (at the "gut" level), have a clear target (the person who can give you the change you want), and have a clear constituency that can influence the target.
- **Organizing vs. Mobilizing.** These words have very specific meanings in community organizing. Mobilizing refers to gathering a group of people for a specific reason to have them do something. After that is done, the group disbands and often the changes do not stick. Organizing refers to building a sustainable group over an extended period of time. This is preferred but takes more time to build.

Christine Holmes, President of Penfield Children's Center – a nonprofit that specializes in early childhood education – gave a background of the importance of early childhood education and then discussed specific interventions for early childhood programs. She stressed that if interventions do not start early, the gap late in life is significant. This can be seen as early as 16 months. Starting early with strong early childhood programming can save money in the long run. The economic power of early education in Wisconsin was demonstrated in a Wisconsin Policy Research Institute report showing savings of $16 for every $1 invested in early childhood education.

Ms. Holmes continued by talking about strategies to focus on to improve early childhood programs. These include:

- Increase parental involvement in early childhood.
- Increase quality of early childhood facilities. For example, there is a problem with the new W-2 policy of paying for childcare by the hour – destroying the quality of the relationship between the family and the childcare provider.
- Provide early screenings such as literacy and kindergarten assessments.
- Reverse trend of disinvesting in early childhood programs.

Ms. Holmes mentioned that there are strong examples to show the success of investing in early childhood, including the Harlem Children's Zone and Lindsay Heights Neighborhood in Milwaukee. These kinds of programs often require strong corporate involvement.

Notes: Participants engaged in conversation around various topics related to early childhood education and community organizing to bring change to communities. Four main themes were discussed:

- **Getting business buy-in.** It is crucial to engage the business community. First, identify who in the business community cares about the issues and is motivated to do something about that. Then, build relationships on an individual level with people in power in the business community. Through building these relationships, convey the benefits of getting involved to them. Think of how to frame the issue so they can sympathize. For example, people with kids are more sympathetic because they want their kids – and all kids – to have benefits. Work toward having a group of businesses who "get" it. You do not need many since even a small size group can have an impact.

  Not all businesses will understand and many have "written off" entire neighborhoods by blaming residents and ignoring the issues. Focus your attention with those businesses that have self-interest in getting involved. Encourage these businesses to fund empowerment of communities.

- **Funding considerations.** We need to stop funding individual programs and focus on investing large amounts of money into initiatives that are joining together for collective impact. Encourage funders to fund community organizing, empowerment and other upstream initiatives. Governments will not be able to play this role as it makes elected officials uncomfortable. The first step is to begin conversations with those in power that have access to funding for these upstream initiatives.

- **The role of upstream issues.** There are many upstream issues related to early childhood education. Most of them center on racism and poverty. Since these are very complicated problems, there is a shift in focus to smaller, less impactful initiatives while the larger problem goes ignored. However, there are places to start that would impact issues such as poverty. These can include improved maternity leave and healthy work environments to support families and children.

- **The role of hope.** There can be a general sense of hopelessness in low-income communities. It is important to support parents and give them hope for the future. Although individual parents may feel powerless, if they can join together as a group, they can start to accomplish things and build hope. Furthermore, all parents have hopes for their kids. This is a good topic around which to organize parents.

Breakout Session Summary
Income-Related Policies

Discussion Leader:

David Reimer – Senior Fellow, Community Advocates Public Policy Institute

Sheri Johnson – Assistant Professor, Medical College of Wisconsin

Summary:

This session was intended to begin a dialogue about income-related policies. David Reimer and Sheri Johnson are both well-known experts in policy and advocacy for low-income communities.

David Reimer spoke about the effectiveness of government in reducing poverty through income-related policies such as social security and food stamps. Although these policies are effective, they have not historically been enough to address the scale of poverty, especially in communities of color.

He further spoke about the poverty policy package that has been identified by his organization – Community Advocates Public Policy Institute. This package, if implemented, has a large potential to dramatically decrease poverty rates, and includes:

- Providing **supplemental income** up to the poverty line for seniors and people with disabilities who are unable to work.
- Expanding **transitional jobs** programs for those who have multiple barriers to employment.
- Raising the **minimum wage.**
- Restructuring the **earned income tax credit** (EITC).

Some of these policies can only become a reality at the federal level; however advocacy and organizing must happen strongly at the local and state levels.

Sheri Johnson spoke about an excellent resource called the "What Works for Health: Policies and Programs to Improve Wisconsin's Health." This is a database of evidence-based policies that can improve health, and it has a section on social determinants of health. She spoke of evidence-based policies that are included in the database, including:

- **Paid Family and Medical Leave (FML).** This policy provides paid time off work for mothers (and sometimes fathers) before or after birth. There is scientific evidence that this decreases infant mortality and improves birth outcomes. Wisconsin does not currently have a paid FML policy. However, under Governor Doyle, Medicaid-eligible moms could have paid FML up to 12 weeks. This has been reduced to 8 weeks under Governor Walker. Dr. Johnson explained that this is not a cost-neutral policy. We could either pay for it now or pay for it later – in the price of poor birth outcomes. However, paying later is much more expensive.
- **Living Wage.** Living wage is higher than minimum wage – it is set to meet the poverty level for a family of four. Local governments can pass living wage ordinances above minimum wage rates. Milwaukee does not currently have a living wage ordinances, however Madison does. The Madison ordinance states that the living wage must be $10.50 per hour, whereas the state minimum wage is $7.50 per hour.
- **Earned Income Tax Credit**. There is a need to expand EITC to non-custodial parents – these would largely be fathers who have an active custody and child support claim. EITC expansion has been cut from the most recent State budget.

Notes: The discussion took the form of audience question and presenter answer. Below is a summary of the four main points:

- **Civic engagement** of the impacted population is essential to improve the policies that most affect them. Instead of placing blame on individuals, empower them to change the policy that most affects them.
- **Changing the narrative** about the W-2 population from one of a needy, dependent population to one of workers who are unemployed and looking for jobs is important. The general population has a more favorable opinion of "workers" as opposed to needy people who need help. Furthermore, people support policies that support workers, such as minimum wage and EITC.
- **Appealing to those with different values** is key**.** The presenters spoke about policy-makers having different values. We have to figure out a way to appeal to the various values that exist, since values cannot be changed. This is done through creating narratives that speak to different political perspectives. Furthermore, a strong focus on civic engagement is needed to build power to make a difference.
- **Changing W-2 policy** so that it mirrors unemployment insurance for those who are looking for a job would also be helpful. This would bring many benefits to recipients, including allowing for access to tax credits and contributing to social security. Furthermore, this would help to change the narrative frame of the population from "needy" to one that is looking for work.

Breakout Session Summary
Healthy Neighborhood Policies

Discussion Leaders:

Nik Kovac – Alderman, Milwaukee's 3rd District

Ann Wilson – Manager, Hillside Family Resource Center for the Housing Authority of the City of Milwaukee

Summary:

This session was intended to begin a dialogue about policies that can improve the built environment in low-income neighborhoods. Two distinctive perspectives were presented: one from a policy-maker, Alderman Nik Kovac and another from the field, Ann Wilson. Alderman Kovac gave his input regarding key neighborhood-level policies, including zoning, affordable housing, transportation and integrated communities. He also spoke about the need for an upstream public health model – one that focuses on social determinants of health, not just service delivery.

Ann Wilson spoke about the need for safe and affordable housing, connecting residents with social services, as well as about social cohesion and involving residents in all initiatives. She spoke about challenges that people living in subsidized housing might face – including access to healthy foods, job assistance, transportation, and access to health care and green space. Policy solutions need to support community partners, including funding choice neighborhoods and community health centers. Finally, she mentioned the need for inter-agency cooperation in solving these complex problems.

Notes: Participants engaged in conversation around various topics related to healthy neighborhoods. Four main themes were discussed:

- **Access to fresh and affordable food.** The conversation began with a discussion about the *need for more education* for families, but especially young mothers, about healthy eating, cooking habits and growing your own food. From there, the conversation expanded to a discussion about the *role of the food environment* in the way people make their eating choices. Participants recognized that a focus on food deserts is critical. They recommended working with current grocery stores to upgrade their existing infrastructure, and working with smaller corner stores to increase the quantity and quality of fresh foods they carry. They discussed the need to "think outside the box" to get to some innovative solutions – such as the use of grocery trucks. Another topic of conversation was *zoning* to decrease "bad" actors such as liquor stores and bring in more "healthy" businesses that offer fresh foods.

- **Access to safe and affordable housing.** Participants first discussed how to work towards giving residents access to permanent housing and decrease the transient nature of low-income communities. Second, they discussed the need to integrate housing with neighborhood development – these two realms go together and should not be dealt with separately. Finally, participants mentioned the need for residents to take initiative in improving their neighborhoods – for example, calling in to report vacant housing.

- **Transportation.** Participants talked briefly about the need for access to public transportation that is within walking distance to various residential neighborhoods, commercial areas and employment.

- **Cooperation.** Participants spoke about the need for cooperation on two levels. The first was regarding the need for collaboration between and within agencies and sectors. Agencies should be sharing what works for them and lessons they have learned along the way. Second, participants talked about the importance of engaging the community in taking action themselves to find solutions to the most prevalent problems.

Breakout Session Summary
Employment Policies

Discussion Leaders:

Paula Penebaker – President and CEO, YWCA of Greater Milwaukee Health Department

Conor Williams – Economic Policy Analyst, Community Advocates Public Policy Institute

Summary:

This session was intended to begin a dialogue about employment issues and their impact on birth outcomes. Two presenters from different backgrounds helped provide different perspectives on the issue. Paula Penebaker gave her remarks from the perspective of a community organization that works with employment issues. Conor Williams gave his remarks as a policy analyst with considerable experience working with employment and other poverty policies.

Paula Penebaker spoke about several barriers to employment for low-income communities in Milwaukee:

- **Lack of affordable, accessible transportation** can cripple worker's access to jobs and employer's access to workers. In a survey conducted of YWCA program participants, 71 percent said they use public transportation to get to work. Many jobs that pay at least a living wage are not located in the city, making transportation a major barrier. Employers outside the city share the same concern. Policy solutions must frame the conversation around good economic strategy. A social angle will not be as effective because of prejudice against job seekers. Racism, which is often institutionalized, presents further complications for workers to find a job that fits their needs and skills.
- **There are huge barriers for ex-offenders gaining employment**, especially for men of color. This is especially crucial because employment is linked with lower rates of recidivism. Policy solutions should consider ways to make it easier for employers to hire before release, regulate the quality of public information on ex-offenders, and provide greater resources to intermediary agencies that link ex-offenders to jobs.
- **Transitional jobs**, or short-term subsidized employment, are one solution to this problem – as they can link ex-offenders with employment. Transitional jobs allow employers to "try-out" an employee without any commitment. In exchange, employees can receive valuable job experience.

Conor Williams spoke further about the correlation between employment and health outcomes, ranging from poor child health to lower life expectancies. Further, he explained that joblessness is the key driver of violent crimes. He mentioned a study that showed that when controlled for employment, the propensity for violent crime is the same across races. This is in direct contradiction to the popular myth that suggests men of color are somehow more likely to commit violent crimes. Another unhelpful myth is the idea that if anybody wants a job, they can get a job. Community Advocates tracks the number of advertised jobs compared to the number of job seekers; according to Mr. Williams there are currently 210,000 job seekers and only 50,000 job vacancies – again in contradiction to the popular message. Mr. Williams also spoke about transitional jobs as an evidence-based solution to decreasing poverty and improving health, however more money needs to be invested in such programs.

Notes:

Participants engaged in conversation around various topics related to employment. In general, the group felt that advocacy needs to happen at various levels and an effort is needed to organize the community to advocate for change. Four main themes were discussed:

- **Education and training for the workforce.** Participants discussed the importance of investing in trades and education to increase the qualified workforce. This needs to start with an investment in high school students. There was also some concern about for-profit colleges and universities that take advantage of lower-income people by providing coursework that doesn't transfer or the education they receive is not of a quality to allow for gainful employment.

- **Employment opportunities for ex-offenders**. Ex-offenders face multiple barriers to employment. A few solutions were offered. Participants spoke of WISDOM's campaign to reduce the incarceration of non-violent offenders from 22,000 to 11,000 by 2015 (known as the "11x15 campaign") as one effort. Another solution offered was to expunge the record of ex-offenders when the person is "off paper" (i.e., no longer on parole or probation) for non-violent crimes, as employer background checks are a large concern for ex-offenders. Further, participants spoke about the fact that substance abuse is considered a public health issue for middle and upper class communities, but is considered a criminal issue in lower class communities, again in the context of employment background checks.

- **Changing neighborhoods.** Participants discussed the changing face of inner city communities, including the departure of employers, hospitals, grocery stores and schools to suburbs. With that, transportation to get to jobs and services are decreasing. This is leading to increased unemployment. Participants wondered how they can foster, create and grow small businesses in low-income neighborhoods.

- **Framing of the issues.** Participants felt that the media do a disservice to the community (especially to black males) on how they present all the negative news that happen in Milwaukee. Participants also felt that we need to change how we talk to one another about these issues and how we understand what works.

Conclusions and Additional Lessons Learned

Overall, this Summit's focus on social determinants of health generated much enthusiasm and support from the broad public health community and its partners. Participants had a chance to listen to two of the nation's leaders in social determinants of health and healthy birth outcomes – Dr. Tony Iton and Dr. Magda Peck. Through the Summit, the City of Milwaukee Health Department was able convene a diverse group of public health professionals, as well as non-traditional partners, as attendees and panelists and speakers. For many of the public health professionals and panelists, this was the first time they were able to interact and share each other's perspectives.

A few lessons learned are worth mentioning:

- It remains very difficult for health care and public health service providers to refocus public health efforts onto foundational social and economic factors. Often this reframing happens only with repeated exposure to social determinants of health concepts. This conference was one such exposure and is certainly not enough for those who were exposed to the concepts for the first time. For this reason, a resource sheet is included in the appendix for participants who want to learn more.
- Similarly, it remains very difficult for health care and public health service providers to reframe public health from a focus on individual service delivery and behavior change to a focus that also includes addressing policy, environmental and systems change. Furthermore, there is a tendency, when policy comes up, to talk about health *care* policy. It appears that social and economic policy is often an uncomfortable topic for many public health and health care practitioners. More work needs to be done to increase awareness and build skills around addressing social and economic issues at the policy or systems level, and the role of public health and health care practitioners and institutions in doing so.
- Although this Summit drew some diversity in terms of public health sectors, it was heavily tilted toward health care systems, including public health providers within health care systems. Future summits should focus recruitment on non-traditional sectors, like some of those represented in the breakout sessions and the final panel discussion – including economic policy analysts, community organizers, urban planners, transportation professionals, etc… By being exposed to each other, traditional public health professionals will gain comfort in collaborating with such non-traditional public health professionals.
- Many participants suggested in the post-summit evaluations that future Summits should focus on case studies and provide evidence-based examples of actions that other institutions and jurisdictions have taken to address social determinants of health. Further, participants wanted to know what they, as public health and healthcare professionals, could do to work on social determinants of health and policy change. In addition, many stated that they would like to reconvene to talk about action steps and work together to accomplish those action steps.

Appendix A

Agenda

11:30 a.m.	**Registration and Networking** – Festa Ballroom
12:00p.m.	**Welcome, Introductions, Housekeeping** Dr. Sheri Johnson
12:10 p.m.	**Welcome** Tom Barrett, Mayor, City of Milwaukee – *invited*
12.15 p.m.	**Welcome** Bevan K. Baker, Commissioner, City of Milwaukee
12.20 p.m.	**Opening Keynote – The Social Determinants of Infant Mortality** Dr. Anthony Iton – Senior Vice President, Healthy Communities, The California Endowment
1:15 p.m.	**Breakout Session One:** (see separate Breakout Description sheet for more information). Choose from: • **Public Policy/Advocacy 101 Workshop** – Conference Room 1 • **Early childcare and education** – Conference Room 2 • **Income-related policies** – Conference Room 3 • **Healthy neighborhoods** – Conference Room 4 • **Employment issues** – Bocce Hall
2:15 p.m.	**Breakout Session Two:** (see separate Breakout Description sheet for more information). Choose from: • **Public Policy/Advocacy 101 Workshop** – Conference Room 1 • **Early childcare and education**– Conference Room 2 • **Income-related policies** – Conference Room 3 • **Employment issues**– Conference Room 4 • **Healthy neighborhoods**– Bocce Hall
3:15 p.m.	**Report out from Breakout Sessions** – Festa Ballroom
3:35 p.m.	**Panel Discussion Q/A:** Breakout Session Leaders and Opening Keynote Speaker
4:15 p.m.	**Closing Keynote**: Dr. Magda Peck, Dean of the Zilber School of Public Health, UW-Milwaukee
4:45 p.m.	**Adjourn**

Appendix B

Evaluation Summary

Overall, 149 participants filled out the evaluation survey (approximately 50%). Summary of questions and answers is below.

Overall, how was your experience at the Infant Mortality Summit? Check one.

□ Excellent--63 □ Good--71 □ Average--2 □ Fair--5 □ Poor--0

Why did you attend the Infant Mortality summit this year? Check all that apply.

- □ Learn more about the influence of SDoH on birth outcomes: 93/149
- □ Learn how I can address SDoH in my work: 84/149
- □ Learn how I can strengthen my SDoH-related work: 85/149
- □ Meet others who are working on SDoH: 69/149

Please rate the impact of this Infant Mortality Summit:

	Strongly agree	Agree	Neutral	Disagree	Strongly Disagree	Total
The content of the sessions was relevant to my work.	68	8	0	0	0	76
The Summit helped me identify and understand the connections between SDoH and birth outcomes.	63	6	11	1	0	81
I am leaving with ideas about how to address SDoH through policy change.	47	7	25	5	0	84
I am leaving with practical next steps that I plan to implement.	25	7	31	10	0	73

What did you like most about this Infant Mortality Summit?

Most common responses and notable quotes are described.

- 83 participants referred to the keynotes speakers. Notable quotes:
  - "Dr. Peck was so motivational."
  - "Keynote speakers were very informative and engaging."
  - "Tony Iton made me thing about public health in a new way."
  - "Dr. Peck is a dynamic speaker and did an outstanding job summarizing the day."
  - "Dr. Iton is a model for the kind of thinking and perspective Milwaukee needs."
- 21 participants referred to the breakout sessions. Notable quotes:
  - "It was nice for the audience to be able to contribute to the dialogue."
  - "Conversations in breakouts and bringing info back to the group. Felt solution-focused."
  - "Very helpful and informative presenters had a lot to offer and very knowledgeable (income/employment)."
  - "Loved the speakers in the breakout sessions."

- 11 participants referred to gaining a new perspective on public health. Notable quotes:
    - "I am a nurse and have looked at this issue mostly from a medical perspective. Great to learn and investigate a different perspective."
    - "Enjoyed the focus on issues other than health care."
    - "Different people – different ideas! Like having an alderman available and someone from 'housing' project that made a difference like Ana."
    - "Great variety of topics. High level ideas which can be applied in variety of settings."
- 11 participants referred to the opportunity to dialogue and network. Notable comments included:
    - "I enjoyed participants expressing their concerns and bringing solutions as well."
    - "Hearing all the brainstorming and discussion and passion from public health workers."
    - "Liked that there were many opportunities for people to comment, ask questions and generated discussion."

What aspects of this event should we work to improve for the next Infant Mortality Summit?
Participants gave us some very helpful feedback which we will incorporate into planning for future events. These recommendations include:

Topical/Content

- Improve consistency of breakout session facilitation
- Emphasize to facilitators that while discussing the role of policy and politics is important, giving a partisan perspective is inappropriate
- Invite affected community to participate in the Summit and provide an opportunity for them to share their perspective
- Focus on concrete action steps that can be taken

Logistical

- Choose a space that can comfortably accommodate all the participants, especially during breakout sessions
- Allow participants to specify their interest in breakout prior to the summit to ensure the rooms are able to accommodate the interest

What kind of follow-up would be helpful to you?
Participants suggested various ways that the City of Milwaukee Health Department can follow-up after the Summit.

- Develop and lead an action group to move forward on issues discussed
- Provide information on action steps and other activities around social determinants of health in which public health practitioners can participate
- Share what other cities are doing to address social determinants of health
- Provide resources to assist public health practitioners in action steps on social determinants of health

What topics would you like to see addressed at future Infant Mortality Summits?
Participants suggested various topics for future Infant Mortality Summits, however overwhelmingly participants felt that the Summit should continue to focus on the same topic, but dig deeper and focus on action steps that can be taken in Milwaukee. Participants felt that it would be useful to provide successes and lessons learned from other cities undertaking initiatives to address social determinants of health.

Appendix C

Resources

This is a select list of useful resources to get more information on social determinants of health.

Wisconsin Center for Health Equity
WCHE is housed in the City of Milwaukee Health Department and demonstrates commitment to working on social determinants of health and health equity. WCHE partners with community, governmental and academic organizations on various initiatives related to health equity. www.wche.org

Unnatural Causes
This series examines how the following factors influence health: childhood/early life, chronic stress, education, food security, genetics, jobs and work, housing/neighborhoods, income and wealth, race/racism, social inclusion, and policy. http://www.unnaturalcauses.org

Health in All Policies
This site, The Aspen Institute, describes how closely health is linked with factors outside the healthcare system, and argues for the inclusion of health in all policies. http://www.aspeninstitute.org/policy-work/health-biomedical-science-society/health-stewardship-project/principles/health-all

Human Impact Partners
This organization is a national leader in Health Impact Assessment, a tool that allows health to be a consideration in decision-making. www.humanimpact.org

Social determinants of health
The World Health Organization provides a global view of the social determinants of health.
http://www.who.int/social_determinants/themes/en/

Whitehall study
This important research project by Michael Marmot discovered that there exists a "social gradient" throughout the world—the relationship between socioeconomic status and health occurs in a stepwise fashion from the poorest of the poor to the wealthiest.
http://www.abc.net.au/science/slab/stress/whithall.htm

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